Client ID#

WELCOME TO

Today's Date: _____

CLIENT INFORMATION

Owner(s) of Pet (Financially responsible):_____ Spouse_____

Address_____
(Street) (Apt #/PO Box)

_____
(City) (State) (Zip)

Primary Phone _____ Cell Phone_____ Work Phone_____

Spouse's Cell_____ E-Mail Address_____

CHECK OUT OUR ONLINE PET PORTAL – PETLY*

How did you hear about us? _____

IN CASE OF AN EMERGENCY

If you and your spouse are unavailable, whom else may we contact regarding your pet's medical treatment?

_____
Name (Relative or friend) Home phone Cell phone

****Our doctors and staff strive to provide the best care possible for your pet. Medical emergencies do sometimes occur even with completely healthy pets. Should an emergency occur, and we are unable to reach you or your emergency contact person, it would be helpful to know your wishes regarding necessary treatments for your pet. Emergencies can be costly due to extensive treatments and medications. Please understand that medical emergencies will involve fees in excess of $200.**

PLEASE INITIAL one of the following options authorizing treatment in case of an emergency.

- Basic stabilization only _____ *(Until you are able to be contacted to discuss treatment options)*
- Any amount of treatment necessary _____ *(see note above)*

PATIENT FINANCIAL POLICY

PAYMENT POLICY: PAYMENT IS DUE AT THE TIME OF SERVICES RENDERED.

_____ *Please initial.* ***OCEANSIDE VETERINARY DOES NOT PROVIDE PAYMENT PLANS OR BILLING.

_____ *Please initial.* *If at any time you are concerned about the cost of a procedure or service proposed by the doctor, a staff member from the office will be pleased to discuss the cost with you prior to having the procedure or service performed.*

For your convenience during checkout, our office accepts cash, checks ($30 RETURNED CHECK FEE), credit cards (Visa®, MasterCard ®, Discover ®, or American Express®) and Care Credit®

Driver's License number is required for check writing privileges (DL#_____)

***By signing below, I understand that I am responsible for charges incurred for animal medical services and that payment of the entire balance upon release of the pet. If for any reason my method of payment is declined, (check returned, credit card charges denied, etc.), I understand that I am responsible for any applicable fees, charges, and collection expense incurred by Ohlandt Veterinary Clinic, P.A.

_____ _____
(Signature) (Date

Client ID#

PET INFORMATION

(1) Pet's name _____Pet's Date of Birth_____(or Approximate Year)

Breed _____ Color _____ Markings_____

Pet Gender: (Check one) Female ☐ *Spayed* ☐ Male ☐ *Neutered* ☐
Please list any chronic major medical problems: _____

(2) Pet's name _____Pet's Date of Birth _____(or Approximate Year)

Breed _____ Color _____ Markings_____

Pet Gender: (Check one) Female ☐ *Spayed* ☐ Male ☐ *Neutered* ☐
Please list any chronic major medical problems: _____

(3) Pet's name _____Pet's Date of Birth _____(or Approximate Year)

Breed _____ Color _____ Markings_____

Pet Gender: (Check one) Female ☐ *Spayed* ☐ Male ☐ *Neutered* ☐
Please list any chronic major medical problems: _____

***Release of information:** Due to South Carolina state laws, veterinarians are required to obtain permission in writing to fax, mail or give verbal information by telephone regarding your animal's health records. Please list below the names of people or facilities we may release such information to. If we are contacted by anyone not listed below, we will contact you.*

	Name of relative, friend, or facility	Contact Number
1.	_____	_____
2.	_____	_____

THANK YOU FOR ALLOWING US TO BE A PART OF YOUR FAMILY! OVC STAFF